

# II. KEY ISSUES IN MINORITY HEALTH

## A. Race and Ethnicity

Racial and ethnic categories used in this report are adopted from the minimum standard racial and ethnic categories for federal reporting established by the federal Office of Management and Budget on October 30, 1997. The five minimum standard race categories are: American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; and White. The two minimum standard ethnic categories are Hispanic or Latino and Not Hispanic or Latino.

In the United States, race is a term used to describe groups of people usually based on distinguishing features such as skin color or other physical characteristics (e.g., shape of nose, eyes, hair texture). However, race is a social construction, and there is no scientific validity for race as a genetic or biological concept.<sup>2,3</sup> Ethnicity refers to a common heritage shared by a particular group, including shared national, geographic, historical, religious, tribal, linguistic, or cultural origins.<sup>4</sup>

The health of racial and ethnic groups is not due to race or ethnicity, per se, but rather, to larger social, political, environmental, and economic factors that are mediated by individual and societal responses to race that can negatively affect health.<sup>5</sup> Race is not a genetic or biological determinant of health, and race and ethnicity should not be used alone as proxies for health risks.<sup>6,7</sup>

# **B. Health Disparities**

The Health of Racial and Ethnic Populations in Wisconsin makes an important contribution to

our documentation and understanding of health disparities in Wisconsin. Health disparities are defined as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Health disparities are discussed relevant to whole population groups—not individual minority group members. Moreover, disparities are so noted even if the rates for Wisconsin minority or non-minority populations are favorable compared to rates for the nation or other states.

The federal *Healthy People 2010* sets health improvement goals for the nation, including a chief goal to eliminate health disparities among segments of the population. These disparities include differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. This report compares disparities in health outcomes (e.g., diseases and deaths), access to care (e.g., health insurance coverage), and social and economic factors (e.g., poverty) across the five major racial/ethnic populations in Wisconsin.

In Wisconsin and throughout the nation, the most persistent disparities in health are usually documented based on socioeconomic status (income, education, employment) and racial/ethnic status. It is important to remember that populations differ in health status for many reasons. These reasons range from the prevalence of risky behaviors (e.g., smoking, alcohol use, poor nutrition, lack of exercise) to limited access to healthcare (e.g., limited insurance coverage). They also range from the burden of poor socioeconomic conditions (e.g., living in communities with few economic resources, increased exposure to violence, social discrimination, housing and recreation located near toxic physical environments) to inadequate healthcare due to discrimination based on race, gender, or language ability.

Persons with low socioeconomic status are more likely to have lower levels of education, less access to healthcare coverage, more exposure to adverse social and environmental conditions, and a greater likelihood of engaging in unhealthy behaviors such as smoking or poor nutrition. The poorer health of individuals, families, and communities with low socioeconomic status is related to a complex interaction of multiple factors and systemic disadvantages related to one's socioeconomic position. Many health disparities are related to societal or institutional inequities that negatively impact racial and ethnic minority populations. Therefore, it is inappropriate to attribute poor health status primarily to individual behavior without acknowledging contextual factors that strongly influence health.

In addition to the well-documented link between socioeconomic status and health, persistent health disparities are also noted by race and ethnicity. Persons from racial/ethnic minority groups generally have worse health than non-Hispanic white populations even when socioeconomic and access-related factors are controlled. This fact was supported in great detail in the Institute of Medicine (IOM) report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. 10 The IOM report found that racial and ethnic minorities receive a lower quality of healthcare and are less likely to receive routine health services, even when controlling for factors such as income, insurance status, age, co-morbid conditions, and symptom expression. These differences were related to barriers at the personal level (e.g., patient preferences, refusal rates); at the provider level (e.g., bias, stereotyping, clinical uncertainty); and at the institutional level (e.g., financing and healthcare delivery regulations).10

The Health of Racial and Ethnic Populations in Wisconsin uses relatively simple health indicators (e.g., mortality and morbidity) to document disparities. However, evidence from national

minority health research and information from Wisconsin communities validate poor health indicators for minority groups related to social, economic, language, and healthcare access barriers that may not be fully captured in data sets that are currently used to document population health status and outcomes in Wisconsin. More complex indicators and measures are needed among disaggregated population groups to describe health and well-being for all population groups and disentangle the root causes of inequalities in health.

Elimination of racial/ethnic health disparities in Wisconsin means that there should be no differences in the rates of diseases, deaths, or other adverse health-related outcomes between a minority population and the majority white population. This report measures a health disparity as a statistically significant difference in the rate between a racial/ethnic minority population and the white population. This relative risk measure is referred as a "disparity ratio." A "disparity ratio" can be used as a simple statistical measure of disparities between a racial/ethnic minority population and the referent white population. If there is no disparity, the "disparity ratio" should compute to "1." Accordingly, a ratio of "1" or less for the minority population of interest is a desired measurement for the goal to eliminate racial/ethnic health disparities.

### C. Determinants of Health

Health is determined by a complex interaction of multiple factors at the individual, healthcare system, and societal levels. While some factors contribute more significantly to health status than others, it is important to note that health is not determined by any single factor. Overall health is the result of multiple and interrelated factors which operate along many complex pathways. Therefore, a full understanding of health in populations should not emphasize how various determinants

of health operate independently, but should seek to discern interactions and patterns across multiple determinants.<sup>11</sup>

Health disparities are strongly influenced by individual factors (e.g., genetics, health behaviors), social and economic inequities, the physical environment, and access to quality healthcare. Figure 1 helps to illustrate these determinants of health which also contribute to health disparities.

Figure 1: Factors contributing to health disparities



The following passages briefly describe how these key determinants of health relate to health disparities among racial/ethnic minority populations.

### **Individual Factors**

Individual behavior. Individual behaviors such as nutrition, smoking, or physical activity can significantly influence health. However, because individuals are a product of their environment, it is inappropriate to attribute health primarily to personal behaviors without also acknowledging contextual factors that influence health. For example, individuals with low socioeconomic status often experience less educational, social, or environmental supports that can encourage less optimal health behaviors.

Nevertheless, the link between health behaviors and socioeconomic status is not always clear. For example, African American women with a college education have higher infant mortality rates than white women with less than a high school education. <sup>12</sup> Although one would expect that women with higher levels of education are more likely to seek adequate prenatal care, individual health-seeking behavior does not appear to significantly reduce black/white perinatal and infant death disparities. Some researchers have posited intergenerational disadvantages, <sup>13,14</sup> and racially mediated stress, <sup>15</sup> as contributing to worse birth outcomes in black vs. white women at all socioeconomic levels. These contextual factors can have a strong impact on health despite individual behavior or biology.

**Genetic Endowment.** Most racial/ethnic health disparities are not caused primarily by hereditary factors, but are related to adverse conditions such as socioeconomic status, environmental circumstances, or access to care that differentially (often negatively) impact persons of racial/ethnic minority groups. Genes are part of the complex web of health determinants, but they are almost always a minor, unstable, and insufficient cause.<sup>7</sup> There is no genetic basis for racial classification<sup>16</sup> and no scientific evidence of a biological link between socially classified "races" (e.g., different skin colors) and health outcomes. Although some genetic conditions (e.g., sickle-cell anemia) are more prevalent in some socially classified racial/ethnic groups (e.g., persons of African or Greek descent), genetic differences can explain only a small percentage of health disparities between racial groups.

### Social and Economic Factors

Racism. Racism is a significant social factor that impacts the health of racial/ethnic minorities. According to a theoretical framework by Dr. Camara Jones of the U.S. Centers for Disease Control and Prevention, racism operates on three levels: institutionalized, personally mediated, and internalized. Institutionalized racism systematically restricts socioeconomic attainment and reduces

# **Determinants of Health**

access to desirable goods and services—including access to quality education, gainful employment, and sound housing—which fosters adverse social and environmental living conditions. Personally mediated racism is intentional or unintentional prejudice and discrimination. Internalized racism is the acceptance and internalization of negative messages and devaluation imposed upon members of stigmatized race groups.

Racism is linked to poor education, lower income, psychosocial stress, and segregated neighborhoods with a greater exposure to harmful environmental conditions and industry advertising (e.g., advertising of cigarettes) that promote risky practices such as smoking, alcohol use, and unhealthy food choices (e.g., neighborhood density of fast food franchises and convenience stores). In addition, racial and social stereotypes in the larger society can influence biases of healthcare providers towards minority patients.<sup>18</sup>

Socioeconomic status. Levels of income, education, and employment can significantly impact health. This report includes poverty, income, education, and employment as indicators of socioeconomic status, and median household income and per capita income as possible indicators of wealth. The data demonstrate that these indicators are lower in racial/ethnic minority populations in Wisconsin compared to the white population.

Although individual socioeconomic status is often cited as a contributing factor to health, less is written about intergenerational wealth advantages and wealth disparities in populations and in societies.<sup>19</sup> Wealth inequalities in a society impact the health of not only those on the lower economic strata, but those with greater economic resources as well. In 1991, the U.S. total median net worth by race and household income was \$44,408 for whites compared to \$5,345 for Hispanics and \$4,604 for blacks. Total median net worth in the lowest quintile was \$10,257 for whites, \$645 for Hispanics, and \$1 for blacks.

In the highest quintile, the total median net worth was \$129,394 for whites, \$67,435 for Hispanics, and \$54,449 for blacks.<sup>20</sup>

Studies have shown that inequalities in the distribution of wealth in societies is associated with higher rates of mortality and reduced life expectancy for all segments of the population.<sup>21</sup> Further analysis is needed to determine how differences in income levels and related indicators such as education, employment, and wealth are linked to health outcomes within and across populations.

### **Environmental Factors**

Physical environment. Health determinants in the physical environment include poor neighborhood conditions, exposure to toxic environments (e.g., closer proximity to diesel bus depots or garbage landfills), and other forms of environmental injustice. Hazardous environments due to lead paint, exposure to second-hand smoke, and exposure to asthma triggers such as dust mites and cockroaches have a higher prevalence in racial and ethnic minority communities in both rural and urban environments. For example, increased exposure to household and external environmental triggers is a factor in the rates of asthma among African American, Hispanic/Latino, and American Indian children nationally and in Wisconsin.

### **Healthcare Factors**

Healthcare. Many studies have documented differences in healthcare by race/ethnicity. 22,23,24 The recent Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, also found differences in the quality of healthcare provided to racial and ethnic minorities compared to the majority white population. 10 The differences persisted even after income, health insurance, stage and severity of disease, comorbidity, and the type of medical facility were taken into account. The Institute of Medicine

concluded that these healthcare disparities were due to the legal and regulatory climate in which health systems function, as well as discrimination at the individual patient-provider level resulting from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making.<sup>10</sup>

### D. Improving Minority Health Data

Health information specific to racial/ethnic minority populations is desired to effectively plan and deliver health services to members of these populations and monitor the progress and outcomes of programs and initiatives designed to reduce and eliminate health disparities.<sup>25</sup> Racial/ethnic data are also important for enforcing civil rights laws, identifying health and healthcare disparities, and promoting understanding of underlying causes, monitoring access to care, and measuring quality of care.<sup>26</sup> However, race and ethnicity identifiers are not uniformly collected, and reporting statistically reliable population health data on small minority populations is challenging.<sup>27</sup> For example, misclassification of race and ethnicity on vital statistics records can result in significant underreporting or overreporting of diseases and death in racial/ethnic minority populations. <sup>27</sup>

Several strategies have been outlined by federal agencies to improve the collection of racial and ethnic health data. Some recommended strategies are: (a) ensure uniform collection and reporting of race and ethnicity identifiers in administrative and medical records of public and private health and human service organizations; (b) use racial and ethnic categories compliant with the Office of Management and Budget standards<sup>1</sup> in all data collection and reporting; (c) encourage self-identification of race and ethnicity to foster accuracy of racial/ethnic coding; (d) increase the sample size of statewide surveys or conduct population-specific surveys targeted to racial and ethnic minorities or medically underserved populations; (e) collect information

such as socioeconomic status, occupation, language proficiency, and health behaviors to understand the underlying causes of disparities; (f) encourage geocoding of health-related data to determine patterns of health and disease among minority populations; and (g) monitor client data within public and private health plans to evaluate differences in healthcare by race/ethnicity.<sup>26,28,29</sup>

Improved minority health data in Wisconsin has been repeatedly requested by several community organizations, tribes, and health organizations in meetings convened by the Division of Public Health. <sup>30</sup> Standard and comprehensive data are needed to enhance our understanding of the processes underlying health disparities and provide a foundation for planning and evaluating of interventions to improve health and eliminate racial and ethnic health disparities. Improving the availability of health data on racial and ethnic populations in Wisconsin will require resources and a coordinated effort by government agencies, public and private health organizations, academic institutions, and local communities.

### E. Healthiest Wisconsin 2010

Wisconsin's state public health plan, *Healthiest Wisconsin* 2010: *A Partnership Plan to Improve the Health of the Public*, outlines priorities and interventions for government, public, private, nonprofit, and voluntary sectors to improve health in Wisconsin communities. The plan has three overarching goals: (a) transform Wisconsin's public health system; (b) promote and protect health for all; and (c) eliminate health disparities.<sup>31</sup>

Healthiest Wisconsin 2010 identifies 11 health priorities to monitor the health of Wisconsin residents over the next decade and beyond. Table 1 lists the 11 public health priorities of Healthiest Wisconsin 2010 and links these priorities to minority health focus areas covered in this report.

Table 1: Healthiest Wisconsin 2010 priorities and Health of Racial and Ethnic Populations in Wisconsin topics

| Health Priorities in Healthiest Wisconsin 2010            | Related Topics in Health of Racial and Ethnic Populations in Wisconsin   |
|---|--|
| Access to primary and preventive health services          | Access to healthcare Health insurance coverage Health screening practices Oral health Geographic distribution Residential segregation Telephone and vehicle access Limited English proficiency Prenatal care |
| Adequate and appropriate nutrition                        | Oral health<br>Diabetes  |
| Alcohol and other drug use and addiction                  | Acute and chronic alcohol drinking<br>Alcohol or drug-related hospitalizations   |
| Environmental and occupational health hazards             | Asthma<br>Childhood lead poisoning<br>Occupational injury deaths   |
| Existing, emerging, and re-emerging communicable diseases | Hepatitis B and C Tuberculosis Adult and childhood immunization  |
| High risk sexual behavior                                 | HIV/AIDS<br>Chlamydia<br>Gonorrhea<br>Syphilis<br>Teen births  |
| Intentional and non-intentional injuries and violence     | Unintentional injuries Occupational injury deaths Homicide Suicide Drinking and driving Motor vehicle crashes  |
| Mental health and mental disorders                        | Depression<br>Schizophrenia<br>Bipolar disorder  |
| Overweight, obesity, and lack of physical activity        | Behavioral health risks<br>Heart disease and stroke<br>Diabetes  |
| Social and economic factors that influence health         | Poverty and income Education Employment Limited English proficiency Foreign-born population Residential segregation Teenage pregnancy  |
| Tobacco use and exposure                                  | Cigarette smoking Smoking during pregnancy Heart disease Asthma Cancer Low birthweight births  |

The Health of Racial and Ethnic Populations in Wisconsin complements the state public health plan by focusing on the goal to eliminate health disparities and will monitor progress in eliminating racial/ethnic disparities in the health priority areas identified in Healthiest Wisconsin 2010.

### **Notes**

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